Emergency Medical Services Authority
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Sacramento, CA 95814-7043
(916) 322-4336
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REQUEST FOR APPROVAL
UNDEFINED SCOPE OF PRACTICE

EMS MEDICAL DIRECTOR:_____ DATE:

LOCAL EMS AGENCY:

NAME OF PROPOSED PROCEDURE OR MEDICATION:_____

1. DESCRIPTION OF THE PROCEDURE OR MEDICATION REQUESTED:

2. DESCRIPTION OF THE MEDICAL CONDITIONS FOR WHICH THEY WILL BE UTILIZED:

3. ALTERNATIVES(Please describe any alternate therapies considered for the same conditions and any advantages and disadvantages):

4. PATIENT POPULATION THAT WOULD BENEFIT, INCLUDING AN ESTIMATE OF FREQUENCY OF UTILIZATION:

5. OTHER FACTORS OR EXCEPTIONAL CIRCUMSTANCES:

PLEASE ATTACH:

6. ANY SUPPORTING DATA, INCLUDING RELEVANT STUDIES AND MEDICAL LITERATURE.

7. RECOMMENDED POLICIES/PROCEDURES TO BE INSTITUTED REGARDING USE, MEDICAL CONTROL, TREATMENT PROTOCOLS, AND QUALITY ASSURANCE OF THE PROCEDURE OR MEDICATION.

8. DESCRIPTION OF THE TRAINING AND COMPETENCY TESTING REQUIRED TO IMPLEMENT THE PROCEDURE OR MEDICATION.